

SUPPLEMENT TO CLAIM OF PERSON OUTSIDE THE UNITED STATES
(To be completed by or on behalf of person who is, was, or will be outside the U.S.)

For Social Security purposes, a person is outside the United States if he or she is physically outside the 50 States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa.

1.	NAME OF WORKER ON WHOSE EARNINGS THIS CLAIM IS BASED				2. WORKER'S SOCIAL SECURITY NUMBER - -	
3.	LIST BELOW THE FULL NAME OF THE WORKER (EVEN IF DECEASED) AND OF EACH BENEFICIARY IN THE SAME HOUSEHOLD WHO IS, WAS OR WILL BE OUTSIDE THE UNITED STATES.	COUNTRY OF BIRTH	COUNTRY WHERE YOU LIVE		COUNTRY(IES) OF PRESENT CITIZENSHIP (Or at time of death)	IF PERSON HAS U.S. PASSPORT, LIST:
PRESENT			OVER NEXT 12 MONTHS	PASSPORT NO.		DATE ISSUED
a.						
b.						
c.						
d.						

Note: All persons listed above or their representative payees must sign the certification in item 18.

4. If any beneficiary listed in item 3 was outside the U.S. this month or any of the past 24 months, or will be in the next 6 months, complete item 4 by entering the name of the beneficiary and dates (month, day and year) he or she was or will be outside the U.S. NOTE: Entries should not be made by residents of Canada or Mexico who are entering the U.S. on a daily basis to work or visit and returning each day to their residence in Canada or Mexico.

NAME	OUTSIDE U.S.		OUTSIDE U.S.		DATE OF EXPECTED RETURN TO U.S. (If within the next 18 months)
	FROM Mo-Day-Yr	TO Mo-Day-Yr	FROM Mo-Day-Yr	TO Mo-Day-Yr	
a.					
b.					
c.					
d.					

5. Has any person listed in item 3 been employed or self-employed outside the U.S. during any of the past 12 months? If "yes," give name and date(s) work began. ☐ Yes ☐ No

NAME	DATE(S)
NAME	DATE(S)

6. Does any person listed in item 3 expect to begin employment or self-employment outside the U.S. in the future? If "yes," give name and date(s) work is expected to begin. ☐ Yes ☐ No

NAME	DATE	NAME	DATE
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LIVING IN THE U.S.							
7.	LIST BELOW THE NAME OF THE WORKER AND OF EACH BENEFICIARY LISTED IN ITEM 3	NO. OF YRS. LIVED IN U.S.	RELATIONSHIP TO WORKER NAMED IN ITEM 1 DURING THIS PERIOD	DATES PERSON LIVED IN THE U.S.			
				FROM Mo-Day-Yr	TO Mo-Day-Yr	FROM Mo-Day-Yr	TO Mo-Day-Yr
a.							
b.							
c.							
d.							

If you need more space, use "REMARKS" on page 3.

8. Answer item 8 only if the worker named in item 1 is deceased.
Did the worker die while in the military service of the U.S. or as a result of disease or injury incurred or aggravated in the military service? ☐ Yes ☐ No

9. Supplementary Medical Insurance generally is payable only for medical services provided inside the United States. If anyone listed in item 3 is now enrolled in Supplementary Medical Insurance under Medicare and wishes to terminate that enrollment, enter his or her name here.

NAME(S)
